MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-025768 STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6758

FILED JUL 5 1963

DO NOT WRITE ON THIS STUB · AMENDED

VS 300 Rev. 4/59

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS — DATE AMENDED — INSTEAD OF — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — DOCUMENT

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USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST.LOUIS CITY HOSP.#1
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MO. b. COUNTY
c. CITY OR TOWN ST.LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 3825 OLIVE
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First CHARLES Middle Last CRAWFORD

4. DATE OF DEATH Month 6 Day 17 Year 63

5. SEX MALE
6. COLOR OR RACE WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH 11/5/97
9. AGE (last birthday) 65
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (City and state or country) ILL.
12. CITIZEN OF WHAT COUNTRY U.S.A

13a. FATHER'S NAME JOHN
13b. MOTHER'S MAIDEN NAME ANNIE OTTO
14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of serv) NO
17. INFORMANT Address ST.LOUIS CITY HOSP. #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pyelonephritis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Septicemia
DUE TO (c) 6000
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes Mellitus

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 6/11/63 to 6/17/63 and last saw her him alive on 6/17/63
Death occurred at 12:55A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or Title) Thomas J Rudgn MD
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 6/17/63

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE 6-29-63
23c. NAME OF CEMETERY OR CREMATORY Anatomical Board
23d. LOCATION (City, town, or county) St. Louis, Mo. (State)

24. FUNERAL DIRECTOR ADDRESS Oaden 4106 Manchester
25. DATE RECD. BY LOCAL REG. JUN 27 1963
26. REGISTRAR'S SIGNATURE Hoard Smith. M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.